History and Context

For a review of the history and purpose of these reports, the reader is referred to the "New TDO Exception Reporting Data Overview" document dated January 2015, which is available on the Department of Behavioral Health and Developmental Services (DBHDS) website at the following link: www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/data.

This is the fifth monthly report of data[1] collected to date from Community Services Boards (CSBs) and regions[2] for fiscal year 2015. The following sections contain the summaries and graphs of the monthly data reported to DBHDS through November 2014. Counts of events are presented for each month and for the state fiscal year (FY) to date for ease of comparison and trend analysis.[3] Additionally, certain high risk events are reported separately by CSBs, on a case-by-case basis as they occur. These involve individuals who are evaluated and need temporary detention, but do not receive that intervention. There were seven such events in November 2014 reporting period.

Each of these events triggers submission of an incident report to the DBHDS Quality Oversight Team[4] within 24 hours of the event. The reports describe the incident and proposed actions to resolve the event and prevent such occurrences in the future. In each case, the Quality Oversight Team reviews the incident report and actions of the CSB for comprehensiveness and sufficiency, and responds accordingly if additional follow up is needed. CSBs continue to update DBHDS until the situation has resolved.

Of the seven events reported in November, three were elopements and four individuals were diverted from temporary detention for urgent medical care. In four of the seven cases, a TDO was subsequently executed and the individual hospitalized while two others agreed to voluntary hospitalization (one for psychiatric care and one for medical care). One individual, who was not in emergency custody, left the hospital following evaluation and was never located despite repeated attempts by law enforcement and CSB staff, and communication by the CSB with his family. Additional detail on each of these cases can be found in Appendix D, page 20.

Graph 1. Emergency contacts statewide

Emergency contacts are events requiring any type of CSB emergency service involvement or intervention. There were 34,032 emergency contacts reported statewide during the month of November, which is a nearly 10% decrease from October. Graph 1, below, displays the statewide number of emergency

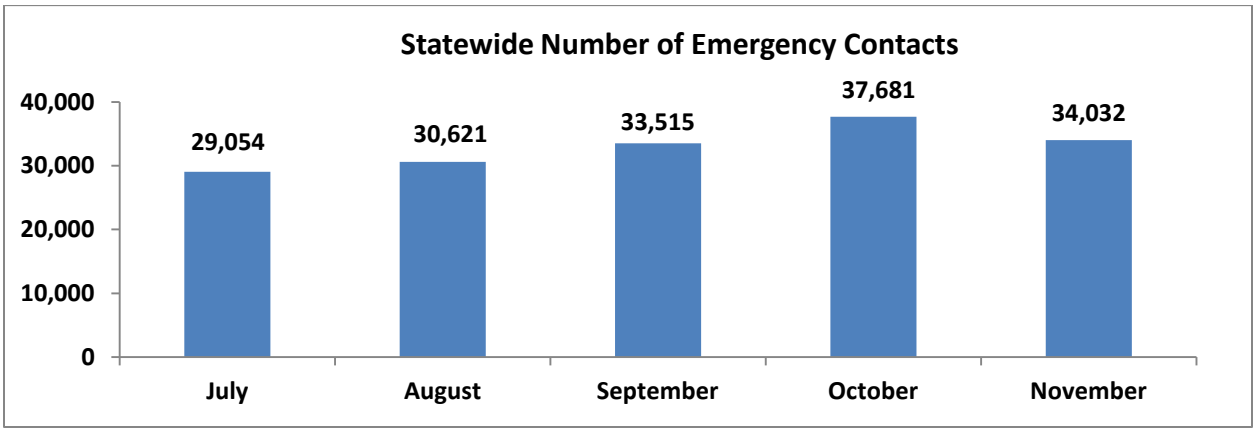
[1] See Appendix A for complete detailed listing of these definitions.

[2] There are 39 Community Services Boards and 1 Behavioral Health Authority in the Commonwealth, referred to in this report as CSBs. See Appendix B for a complete listing of CSBs within each of the seven regions.

[3] In addition, data is reported both statewide and by region in the report and in Appendix C.

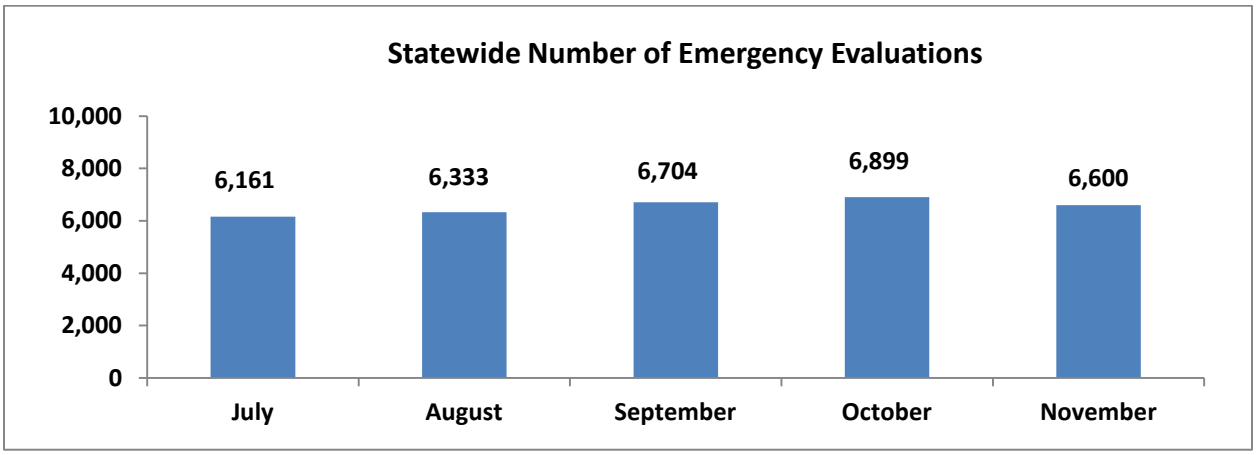
[4] Reports are submitted to the DBHDS Medical Director, Assistant Commissioner for Behavioral Health, Director of Mental Health, and MH Crisis Specialist.

contacts for July through November. Regional data is displayed in graph 1a and table 1 in Appendix C, page 11. The biggest decreases in regional numbers were in Region 1 (22% reduction in contacts), Region 6 (16% reduction) and Region V (14%). Regions 2 and 3 experienced slight increases in emergency contacts in November.



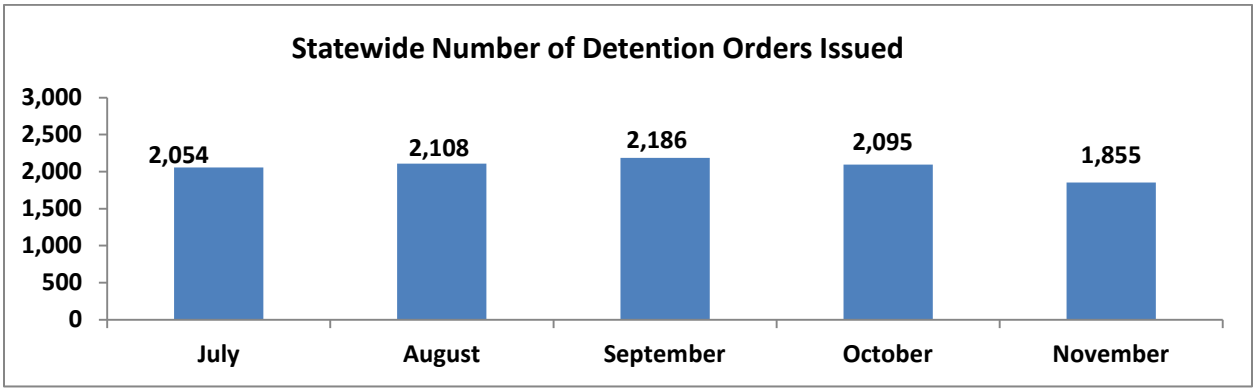
Graph 2. Emergency evaluations statewide

Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis (these exams may be conducted electronically by two-way video and audio communication). The number of emergency evaluations reported statewide in November was 6,600. This is a decrease of about 4% from October, following a general trend upward since July (Graph 2). Since DBHDS initiated discussion with Region 7 to identify and address factors contributing to their data, there has been approximately a 32% decrease in the number of emergency evaluations in that region from October to November. This may also be attributed to the clarification of data element definitions issued during November, 2014 as well as the efforts of the region to involve key stakeholders in discussions regarding timely care. Regional data is displayed in graph 2a and table 2 in Appendix C, page 12. Region 1 and 2 reported increases in evaluations over the previous month. The increase in Region 1 was slight, but the increase in Region 2 was 15%, well outside the trend of the other regions and state. The figures for emergency contacts, emergency evaluations, and TDOs that are reported in subsequent pages of this report may represent duplicated (i.e., not mutually exclusive) counts of individuals because an individual may have made contact, or been evaluated or detained, on more than one occasion and could therefore be included two or more times in any of these categories.



Graph 3. TDOs issued statewide

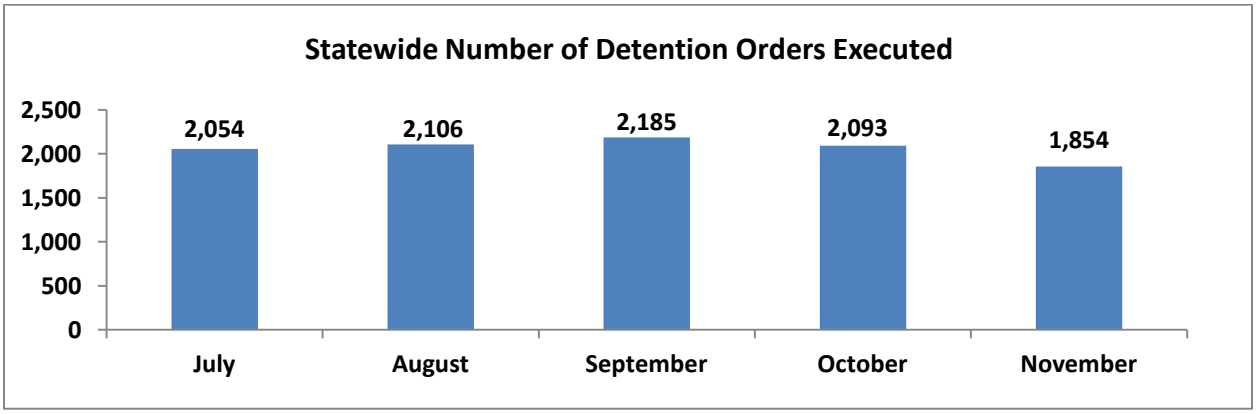
A TDO is issued by a magistrate after considering the results of the CSB evaluation and other relevant evidence, and determining that the person meets the criteria for temporary detention under § 37.2-809 or § 16.1-340.1. A TDO is executed when the individual is taken into custody by the officer serving the order. In November, there were 1,855 TDOs issued (Graph 3), and 1,854 TDOs executed (Graph 4). Graph 3a and table 3 (page 13) and graph 4a and table 4 (page 14), display this data by region in Appendix C. This is a reduction of 239 TDOs from the prior month, representing a decrease of approximately 11% percent from October. These figures are the lowest monthly totals of the year to date for both categories**.** The statewide decrease is reflected at the regional level for all regions. **About 72% of the emergency evaluations in November (4,745 of 6,600) did not result in a TDO.**



Graph 4. TDOs executed statewide

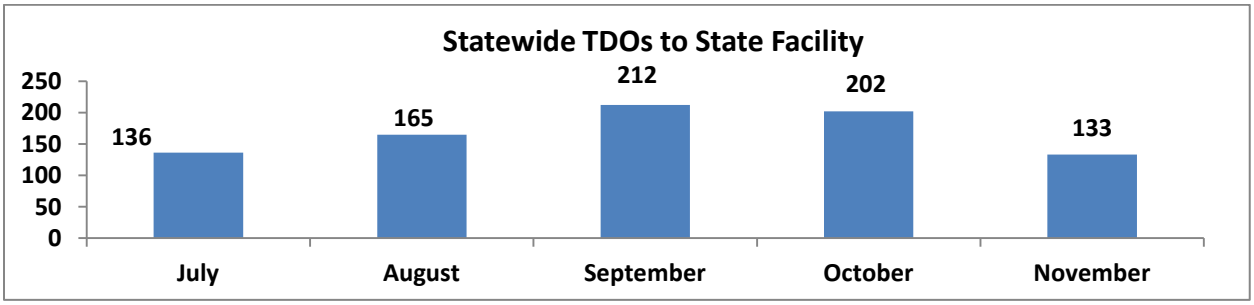
There was one TDO issued but not executed during the month of November. This event occurred after the CSB had assessed an individual and was seeking a TDO from the magistrate. Without consulting anyone and despite knowing that the CSB was obtaining a TDO, the attending physician in the emergency department arranged for the individual to be transferred from the ED to a medical facility where the

individual was medically admitted. The TDO paperwork was returned to the magistrate. This case was reported within 24 hours to DBHDS and is summarized in Appendix D, case 6.



Graph 5. TDO admissions to a state hospital statewide

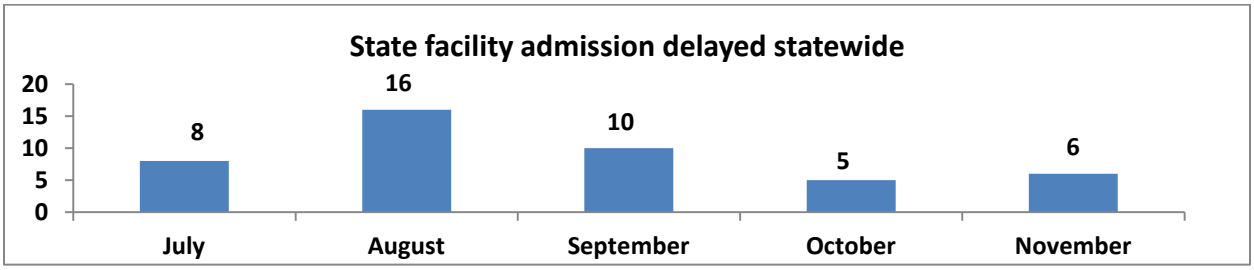
Of the 1,854 TDOs executed in November, 133 (7%) resulted in the individual being admitted to a state hospital [5] (Graph 5). This is a decrease of 34% from October, and is the lowest monthly total of the year to date. Significant reductions in state hospital TDO admissions occurred at the regional level as well, except for Region 1, which had only one fewer TDO admission to a state hospital than in October. A significant portion of the November decrease in TDOs statewide appears to have accrued to state hospitals, where there were 69 fewer state hospital TDO admissions (of 239 fewer TDOs executed statewide) in November. There continues to be variance among regions in the number of state hospital TDO admissions, as shown in Graph 5a and table 5 in Appendix C, page 15. This variance reflects each region's unique resources and protocols. Region 3, for example, encompasses a large geographic area (southwest Virginia) with limited access to community psychiatric facilities, and is more reliant on state facilities, as compared to other regions. DBHDS tracks these indicators and trends and is working with the regions to minimize usage of state facilities during the TDO process through increased use of community psychiatric resources, alternatives to hospitalization, and more explicit utilization protocols for state hospitals.



[5] Source: DBHDS AVATAR admitting CSB data

Graph 6. State hospital admission delayed statewide

In November, there were six occasions wherein the state hospital was deemed the "hospital of last resort" but admission could not be accomplished before the ECO time period expired due to more immediate medical treatment needs (including intoxication), and in two instances, due to technological difficulties with fax machines used to transmit information between providers (Graph 6). All of these individuals were ultimately admitted to the state psychiatric hospital. This is an increase from October of one additional case, but still maintains the downward trend since August. Graph 6a and table 6 displays this data by region in Appendix C, page 16, and shows that regions 4, 5, and 7 did not experience this type of occurrence in October.

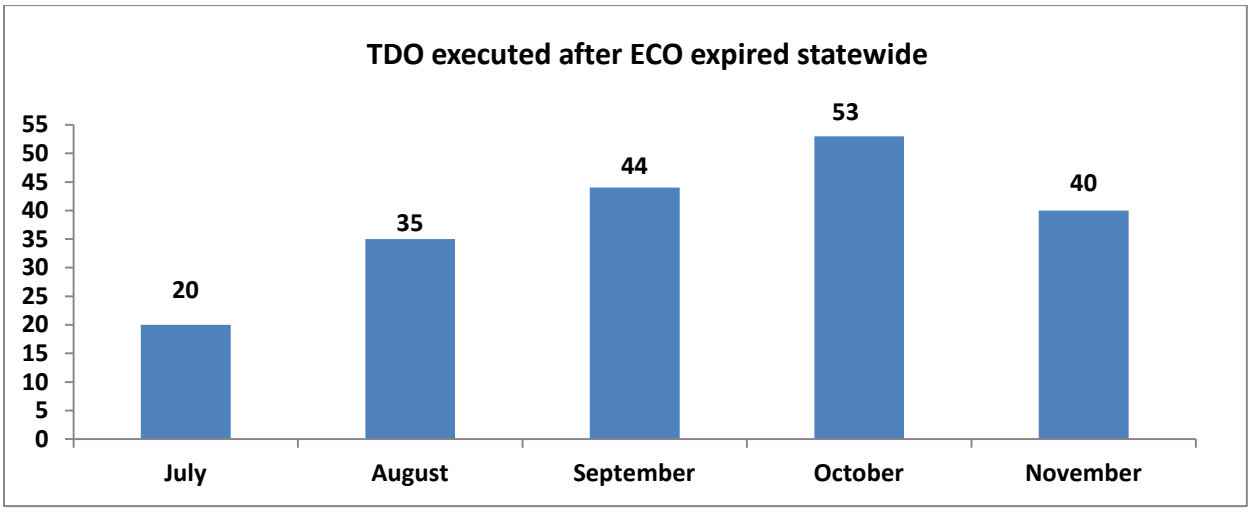


Graph 7. TDO executed after ECO expired statewide

In November, there were 40 (2%) reported cases where a TDO was issued but not executed until after the ECO period had ended (Graph 7). This is about a 25% decrease from October, after a steady upward trend from July. Since July, several CSBs have sought clarification from DBHDS and received additional direction on reporting this type of event. The decrease reported in November may reflect, in part, changes in CSB reporting practices resulting from DBHDS guidance. In most of these cases, the individuals remained safely within an emergency department, a medical unit in a hospital, a crisis assessment center, or in CSB offices without incident until the TDO could be executed. Three of the events occurred at CSB offices where no law enforcement or security was present. In two cases, the individual eloped from the CSB office while the CSB was awaiting the arrival of law enforcement with the TDO. Providers continue to utilize physically secure environments (such as a locked emergency department or secure assessment sites) and physical restraint, as well as law enforcement officers, to maintain custody. Graph 7a and table 7 display this data by region in Appendix C, page 17. Regions 1, 4 and 6 did not experience this type of event in November.

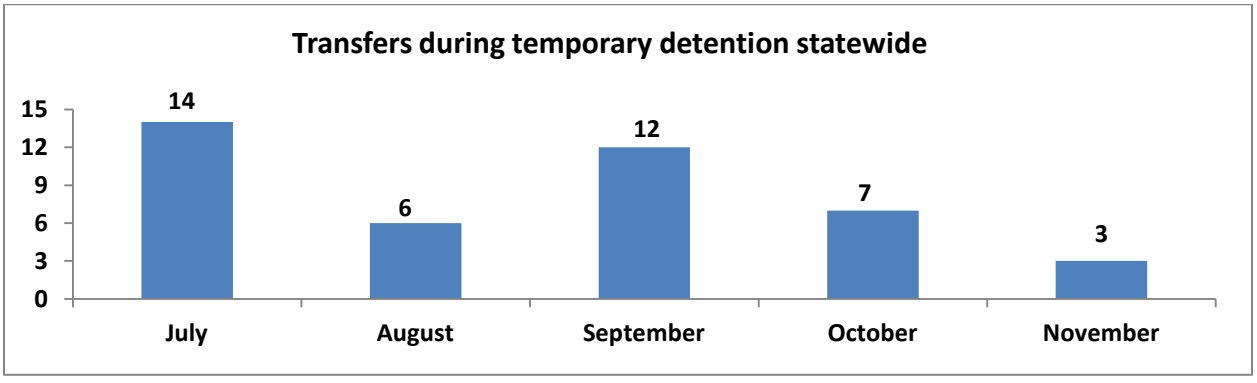
Region 7 continues to have a significantly greater number of these cases. This region's reported 100 TDOs issued and executed during November, 2104, and 40% were executed after the ECO period expired. The time ranges from 40 minutes to 16 hours and 15 minutes with a mean of 4 hours and 22 minutes from time of issuance to execution. In response to these data, in December, DBHDS engaged Blue Ridge Behavioral Health (BRBH), the CSB serving the five metropolitan Roanoke area jurisdictions, in a quality improvement effort to identify the primary drivers of these cases. The CSB has subsequently had discussions with the City of Roanoke Sheriff to improve timeliness of the sheriffs' response, and also

reviewed the regional medical screening protocols with Catawba Hospital to ensure no delays are caused by this protocol. BRBH continues to investigate the issue and regularly reports the progress of their improvement effort to DBHDS to ensure continued oversight. Region 7 still has the highest number of these reported cases, but there was a 14% decrease from October for this region.



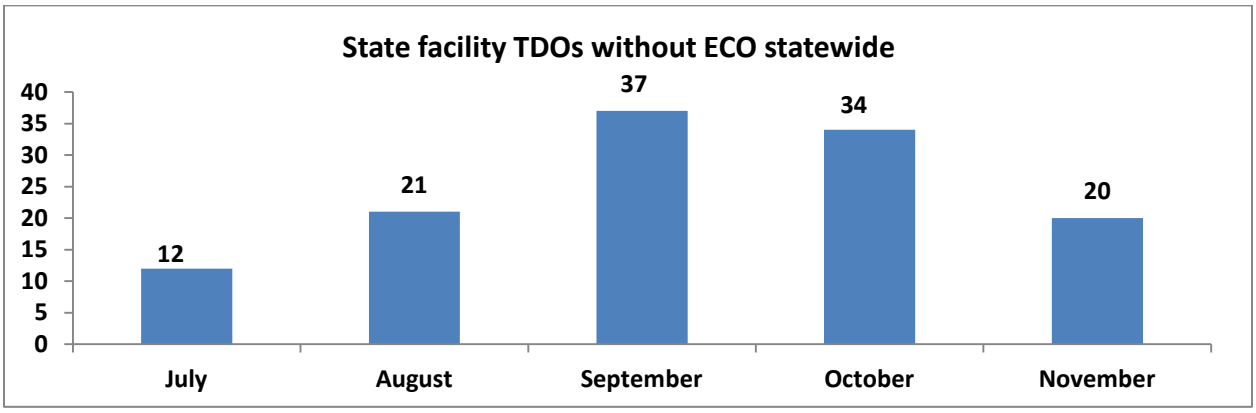
Graph 8. Transfers during temporary detention statewide

Section § 37.2-809.E. of the *Code of Virginia* allows an individual to be transferred during the period of detention from one temporary detention facility to another more appropriate facility in order to address an individual's security, medical or behavioral health needs. This procedure was used only 3 times (<1%) during November (Graph 8). In two cases, the transfer was from a state facility to a private facility to utilize a more appropriate community alternative, and one case was a transfer from a medical hospital to a private psychiatric facility. These three cases are a 57% decrease from October and the lowest monthly total since July. This figure also continues a downward trend since September. Graph 8a and table 8 displays this data by region in Appendix C, page 18. Regions 1, 2, 3, 6 and 7 did not report any of these transfers in November.



Graph 9. State hospital TDOs without ECOs statewide

As the "hospital of last resort", DBHDS facilities admit individuals who need temporary detention for whom no alternative placement can be found, whether or not the individual is under an ECO. CSBs report every "hospital of last resort" admission where no ECO preceded, along with how many alternate facilities were contacted and the reason(s) for the inability to locate an alternate facility. In November, there were 20 such admissions to a state facility, which is a 41% decrease from October and continues a downward trend since September (Graph 9). A total of 183 contacts were made for an average of nine alternate facilities contacted in each of these 20 instances. Ten of the admissions were for specialized care due to the individual's age (either a minor or adult aged 65 and older) while six of the admissions were due to lack of capacity of the alternate facilities contacted by the CSBs. Other reasons for these admissions were diagnosis of intellectual or developmental disability; medical needs beyond the capability of the alternate facilities contacted; and aggressive behaviors not manageable in the alternative facilities contacted. Graph 9a and table 9 displays this data by region in Appendix C, page 19.



Discussion:

To enhance consistency and accuracy of CSB reporting, DBHDS has worked continuously since July with CSBs and regional managers, both individually and collectively, to identify data elements or reporting procedures that were not clearly or consistently understood. In November 2014, DBHDS issued comprehensive clarifying revisions to both the monthly reporting forms and data definitions. The DBHDS, in collaboration with CSB's, has established a workgroup consisting of CSB Executive Directors. Emergency Services Directors, and DBHDS representatives to further strengthen the quality oversight processes and ensure this and other data is consistently used by CSBs to identify trends and correct problems at the agency, regional, and statewide levels. These data enable DBHDS to conduct ongoing system monitoring and performance improvement efforts. As a result, DBHDS, CSBs, and local emergency service partners are communicating more regularly and timely to improve local care coordination, eliminate system gaps and clarify agency and staff roles in the emergency response system. Lastly, DBHDS has convened stakeholder meetings at the state level, and will continue to do so to share

this data, communicate directly about problem issues, and jointly develop and implement effective operational improvements.

APPENDIX A

Data Elements Reported Monthly by CSB/BHAs

Each CSB/BHA reports four data factors on volume to the region:

1. Emergency contacts: The total number of calls, cases, or events per month requiring any type of CSB emergency services involvement or intervention, whether or not it is about emergency evaluation, and regardless of disposition. Calls seeking information about emergency services, potential referrals, the CSB, etc., should be counted if the calls come to emergency services (e.g., through the crisis line) and require emergency services to respond. Any other contacts to emergency services from individuals, family members, other CSB staff, health providers or any other person or entity, including contacts that require documentation in an individual's health record, should be counted as emergency contacts. Any contacts that precipitate an intervention or emergency response of any kind should be counted as emergency contacts.
2. Emergency Evaluations: Emergency evaluations are clinical examinations of individuals that are performed by emergency services or other CSB staff on an emergency basis to determine the person's condition and circumstances, and to formulate a response or intervention if needed. This figure is the total number of emergency evaluations completed, regardless of the disposition, including evaluations conducted in person or by means of two-way electronic video/audio communication as authorized in 37.2-804.1.
3. Number of TDOs Issued: TDOs are issued by a magistrate.
4. Number of TDOs Executed: TDOs are executed by law enforcement officers. A TDO is executed when the individual is taken into custody by the law enforcement officer serving the temporary detention order. It is possible under some circumstances that a TDO issued by a magistrate may not be executed for some reason.

Each CSB/BHA also reports six additional data elements:

1. Cases where the state hospital was used as a “last resort”: Under the new statutory procedures effective July 1, 2014, when an individual is in emergency custody and needs temporary detention, and no other temporary detention facility can be found by the end of the 8-hour period of emergency custody, then the state hospital shall admit the individual for temporary detention. Each region's Regional Admission Protocol describes the process to be followed for accessing temporary detention facilities and for accessing the state hospital as a "last resort" facility for temporary detention.
2. Cases where a back-up state hospital was used: Under some circumstances, the primary state hospital may not be accessible as the "last resort" temporary detention facility when needed at the end of the 8-hour ECO period, and a back-up state hospital will need to admit the individual as a "last resort" admission.
3. Cases where the state hospital is called upon as the "last resort" for temporary detention, but admission cannot occur at the 8-hour expiration of the ECO because of a medical or related

clinical issue that must be addressed (i.e., medical condition cannot be treated effectively in the state hospital, person is not medically stable for transfer to state hospital, required medical testing is not yet completed, etc.).

4. Cases where a TDO may be issued by a magistrate while the person is in emergency custody, but the TDO will not be executed until after the 8-hour period of emergency custody has expired. Under the new statutes, if this scenario should occur, the individual may not be released from the CSB's custody until the TDO is executed.
5. Cases where a facility of temporary detention is transferred post-TDO: a CSB is allowed to change the facility of temporary detention for an individual at any time during the period of temporary detention pursuant to 37.2-809.E.
6. Cases where there is no ECO, but TDO to state hospital as a “last resort”: These are instances when an individual who is not in emergency custody (i.e., no ECO) is deemed to need temporary detention. If no suitable alternative facility can be found, state hospitals must serve as the "last resort" temporary detention facility in these cases.

Note: For the six data elements immediately above, associated descriptor information is reported as well.

APPENDIX B

Partnership Planning Region	Community Services Board or Regional Behavioral Health Authority
1 Northwestern Virginia	Horizon Behavioral Health Services Harrisonburg-Rockingham CSB Northwestern Community Services Rappahannock Area CSB Rappahannock-Rapidan CSB Region Ten CSB Rockbridge Area Community Services Valley CSB
2 Northern Virginia	Alexandria CSB Arlington County CSB Fairfax-Falls Church CSB Loudon County CSB Prince William County CSB
3 Southwestern Virginia	Cumberland Mountain CSB Dickenson County Behavioral Health Services Highlands Community Services Mount Rogers CSB New River Valley Community Services Planning District One Behavioral Health Services
4 Central Virginia	Chesterfield CSB Crossroads CSB District 19 CSB Goochland-Powhatan Community Services Hanover CSB Henrico Area Mental Health & Developmental Services Board Richmond Behavioral Health Authority
5 Eastern Virginia	Chesapeake CSB Colonial Behavioral Health Eastern Shore CSB Hampton-Newport News CSB Middle Peninsula-Northern Neck CSB Norfolk CSB Portsmouth Department of Behavioral Healthcare Services Virginia Beach CSB Western Tidewater CSB
6 Southern	Danville-Pittsylvania Community Services Piedmont Community Services Southside CSB
7 Catawba Region	Alleghany Highlands CSB Blue Ridge Behavioral Healthcare

APPENDIX C

Graph 1a. Emergency contacts by region

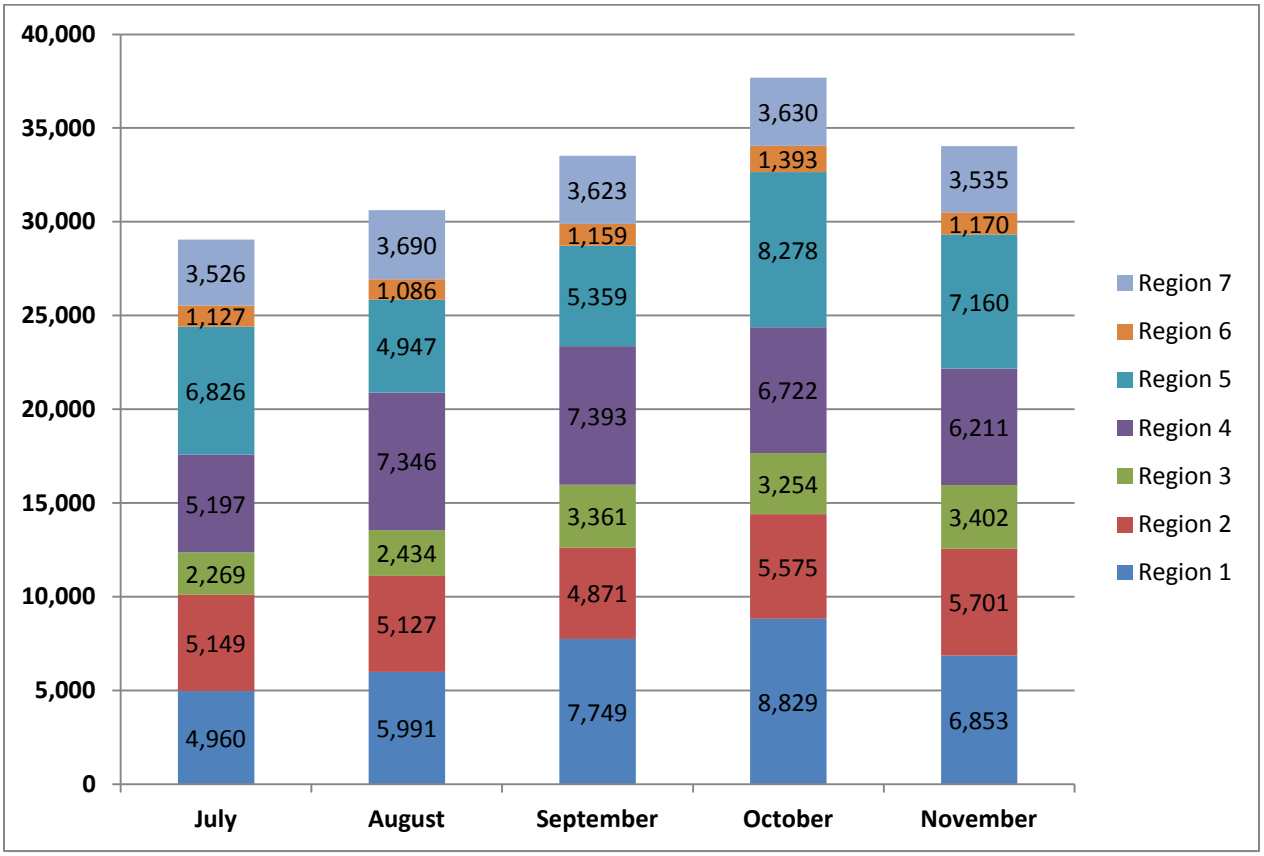


Table 1. Number of emergency contacts (corresponds with graph 1a)

Region	July	August	September	October	November	Total
Region 1	4,960	5,991	7,749	8,829	**6,853**	**34,382**
Region 2	5,149	5,127	4,871	5,575	**5,701**	**26,423**
Region 3	2,269	2,434	3,361	3,254	**3,402**	**14,720**
Region 4	5,197	7,346	7,393	6,722	**6,211**	**32,869**
Region 5	6,826	4,947	5,359	8,278	**7,160**	**32,570**
Region 6	1,127	1,086	1,159	1,393	**1,170**	**5,935**
Region 7	3,526	3,690	3,623	3,630	**3,535**	**18,004**
Total	**29,054**	**30,621**	**33,515**	**37,681**	**34,032**	**164,903**

Graph 2a. Emergency evaluations by region

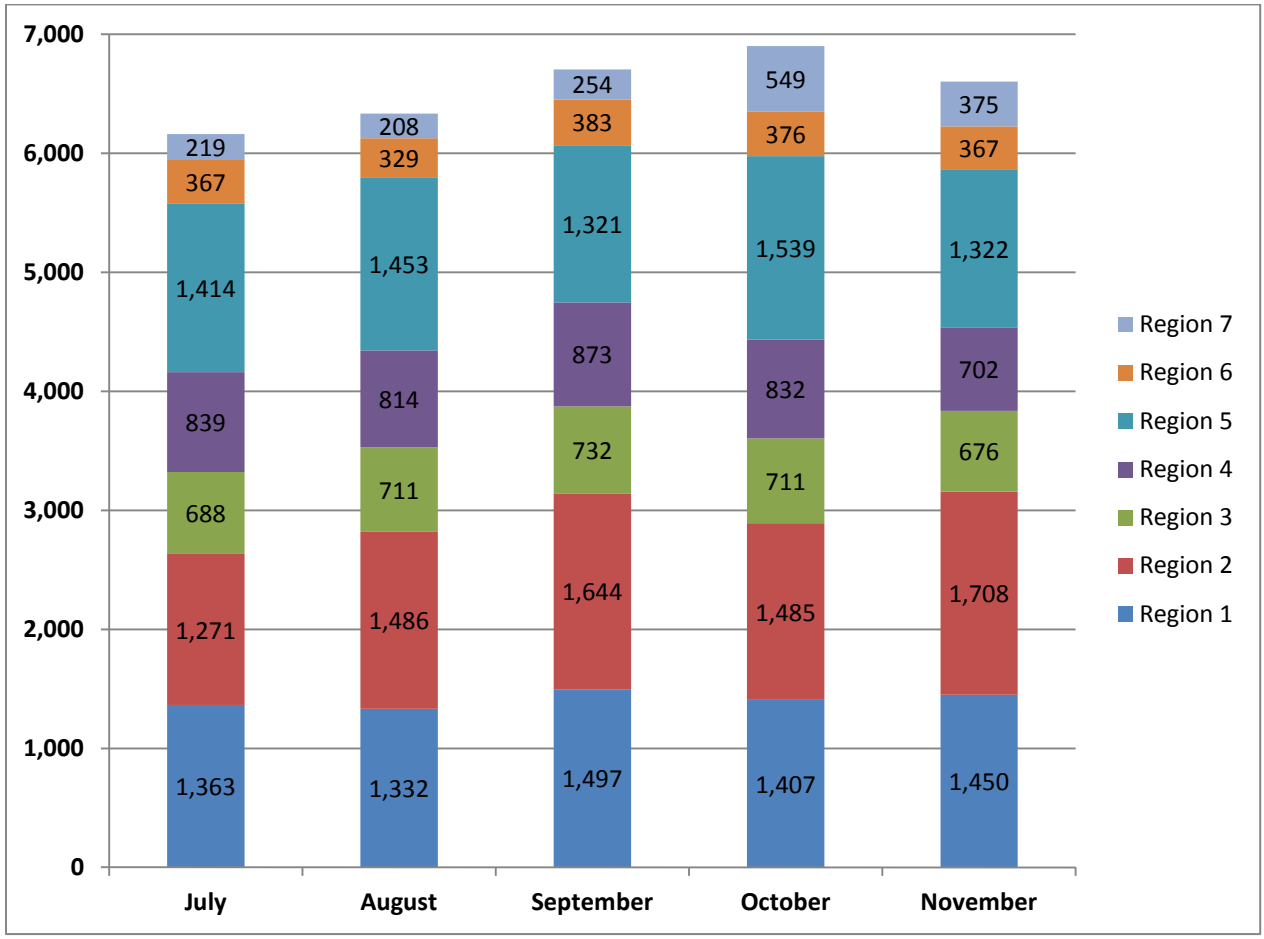


Table 2. Number of emergency evaluations (corresponds with graph 2a)

Region	July	August	September	October	November	Total
Region 1	1,363	1,332	1,497	1,407	**1,450**	**7,049**
Region 2	1,271	1,486	1,644	1,485	**1,708**	**7,594**
Region 3	688	711	732	711	**676**	**3,518**
Region 4	839	814	873	832	**702**	**4,060**
Region 5	1,414	1,453	1,321	1,539	**1,322**	**7,049**
Region 6	367	329	383	376	**367**	**1,822**
Region 7	219	208	254	549	**375**	**1,605**
Total	**6,161**	**6,333**	**6,704**	**6,899**	**6,600**	**32,697**

Graph 3a. TDOs issued by region

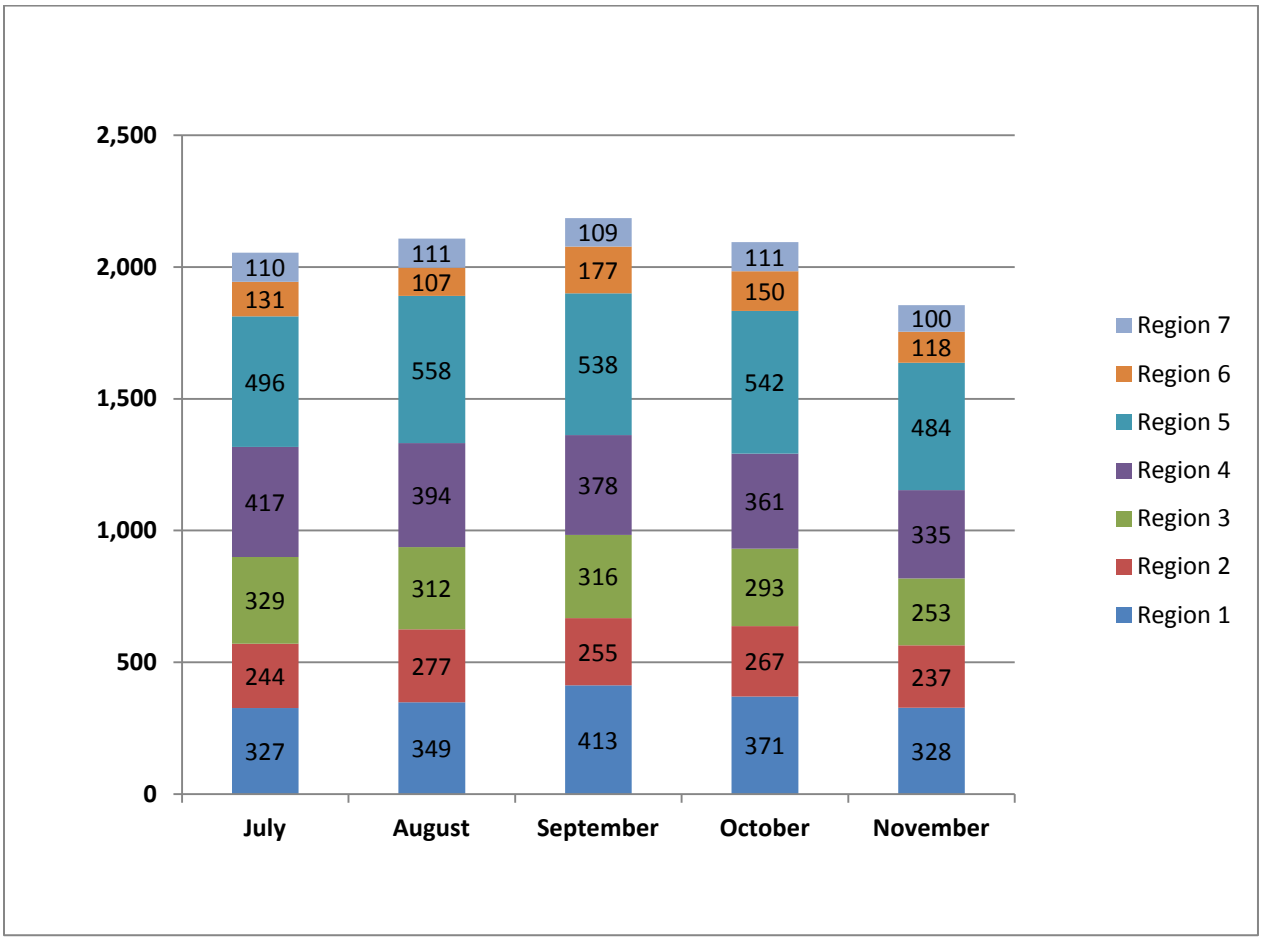


Table 3. Number of TDOs issued (corresponds with graph 3a)

Region	July	August	September	October	November	Total
Region 1	327	349	413	371	**328**	**1,788**
Region 2	244	277	255	267	**237**	**1,280**
Region 3	329	312	316	293	**253**	**1,503**
Region 4	417	394	378	361	**335**	**1,885**
Region 5	496	558	538	542	**484**	**2,618**
Region 6	131	107	177	150	**118**	**683**
Region 7	110	111	109	111	**100**	**541**
Total	**2,054**	**2,108**	**2,186**	**2,095**	**1,855**	**10,298**

Graph 4a. TDOs executed by region

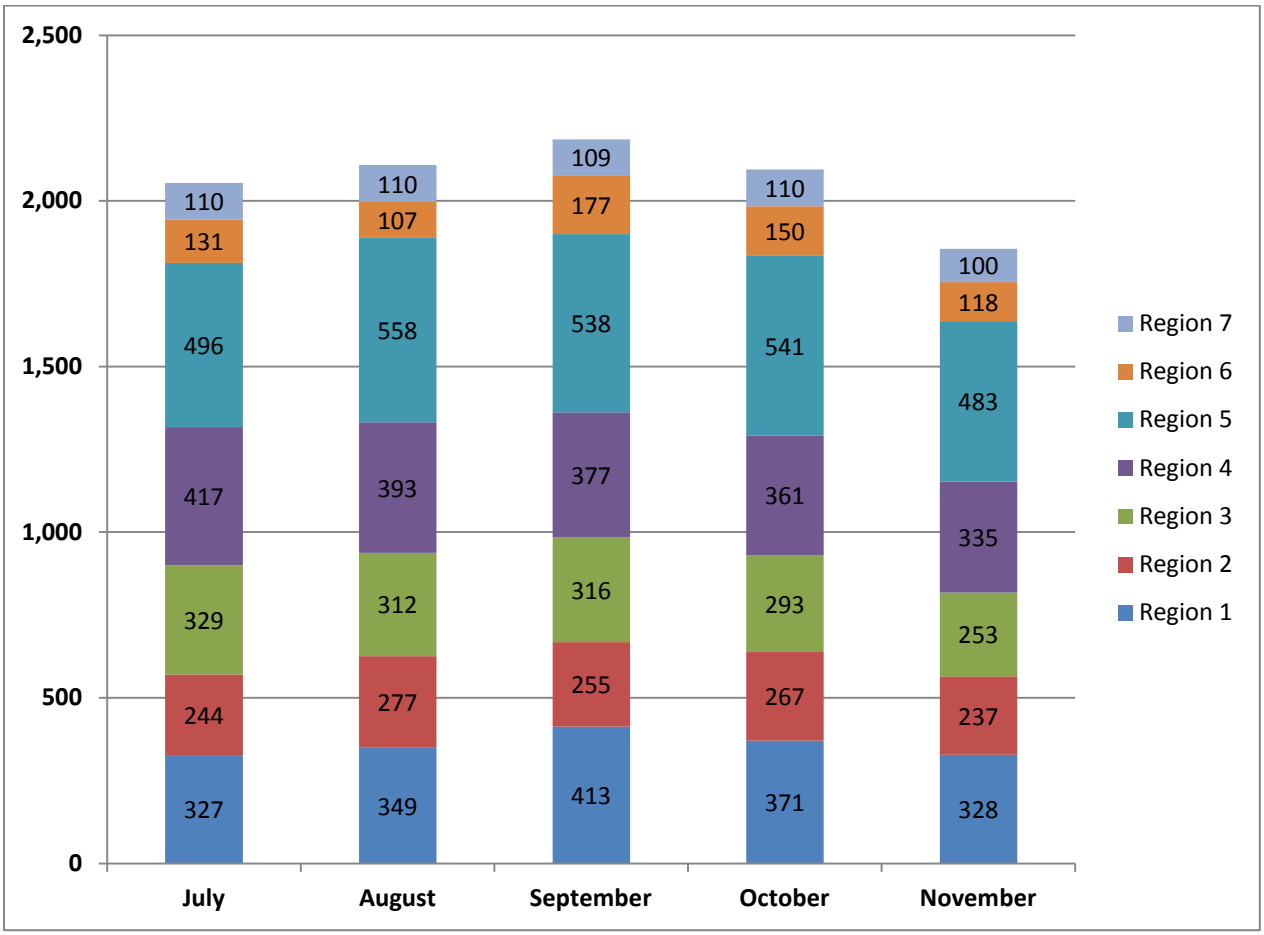


Table 4. Number of TDOs executed (corresponds with graph 4a)

Region	July	August	September	October	November	Total
Region 1	327	349	413	371	**328**	**1,788**
Region 2	244	277	255	267	**237**	**1,280**
Region 3	329	312	316	293	**253**	**1,503**
Region 4	417	393	377	361	**335**	**1,883**
Region 5	496	558	538	541	**483**	**2,616**
Region 6	131	107	177	150	**118**	**683**
Region 7	110	110	109	110	**100**	**539**
Total	**2,054**	**2,106**	**2,185**	**2,093**	**1,854**	**10,292**

Graph 5a. TDO admissions to a state hospital by region

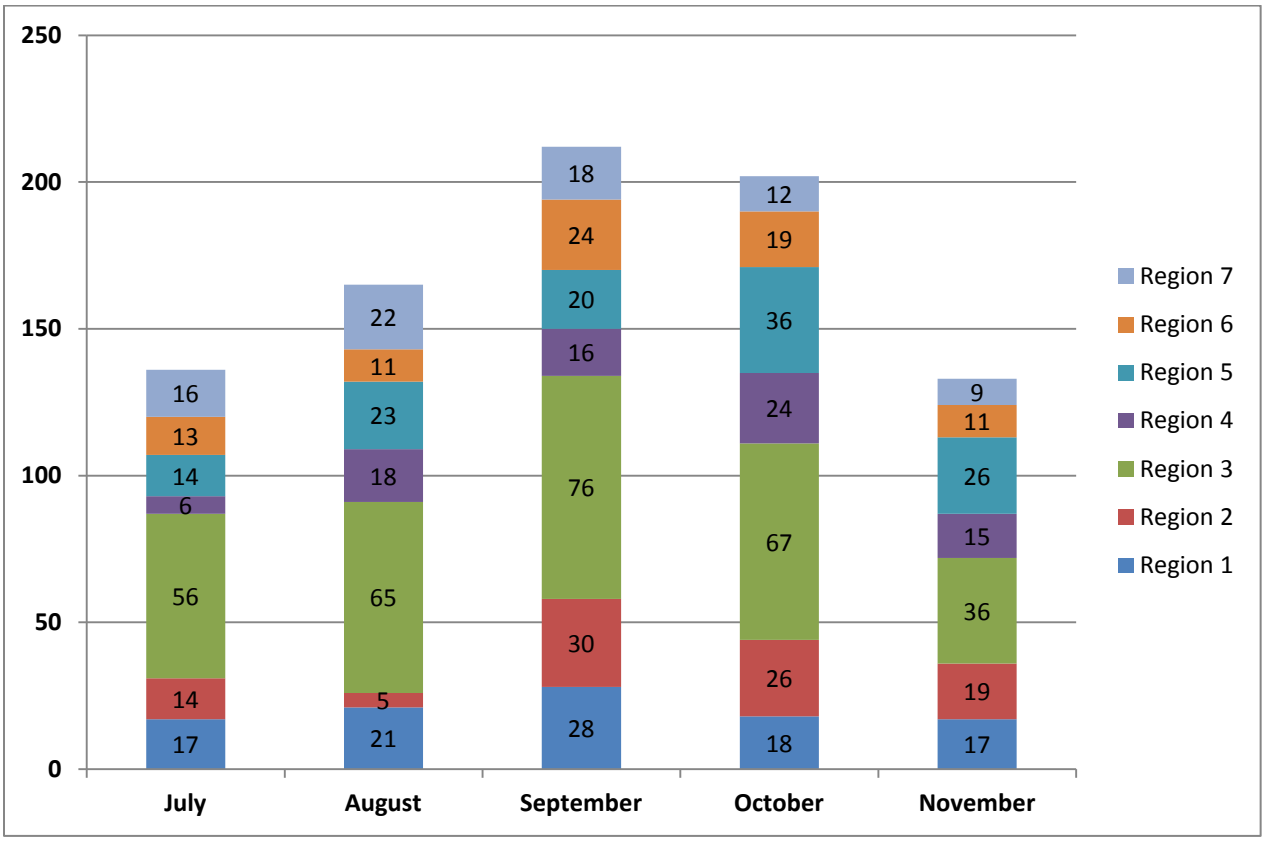


Table 5. TDO admissions to a state hospital (corresponds with graph 5a)

Region	July	August	September	October	November	Total
Region 1	17	21	28	18	**17**	**101**
Region 2	14	5	30	26	**19**	**94**
Region 3	56	65	76	67	**36**	**300**
Region 4	6	18	16	24	**15**	**79**
Region 5	14	23	20	36	**26**	**119**
Region 6	13	11	24	19	**11**	**78**
Region 7	16	22	18	12	**9**	**77**
Total	**136**	**165**	**212**	**202**	**133**	**848**

Graph 6a. State hospital admission delayed by region

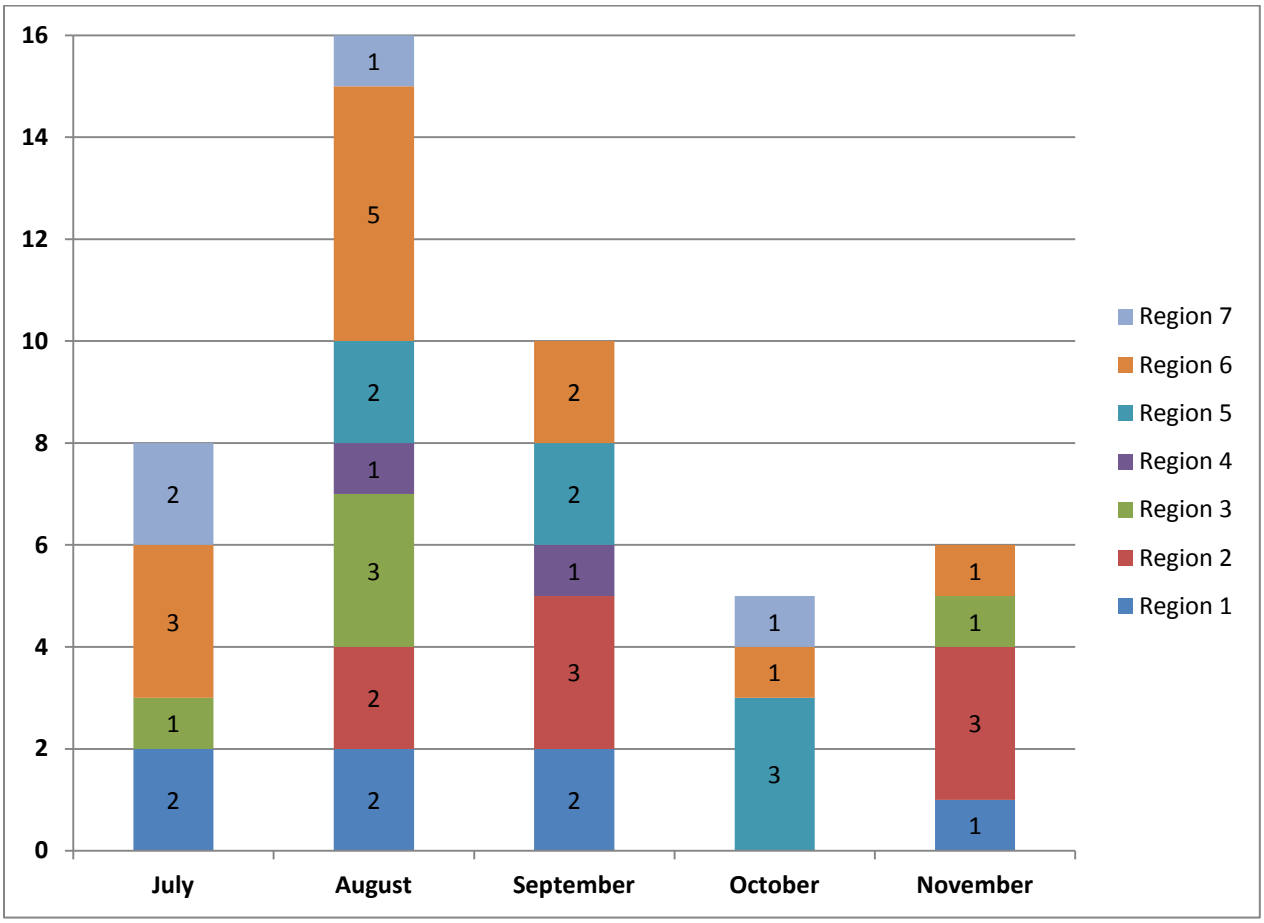


Table 6. State hospital admission delayed (corresponds with graph 6a)

Region	July	August	September	October	November	Total
Region 1	2	2	2	0	**1**	**7**
Region 2	0	2	3	0	**3**	**8**
Region 3	1	3	0	0	**1**	**5**
Region 4	0	1	1	0	**0**	**2**
Region 5	0	2	2	3	**0**	**7**
Region 6	3	5	2	1	**1**	**12**
Region 7	2	1	0	1	**0**	**4**
Total	**8**	**16**	10	**5**	**6**	**45**

Graph 7a. TDO executed after ECO expired by region

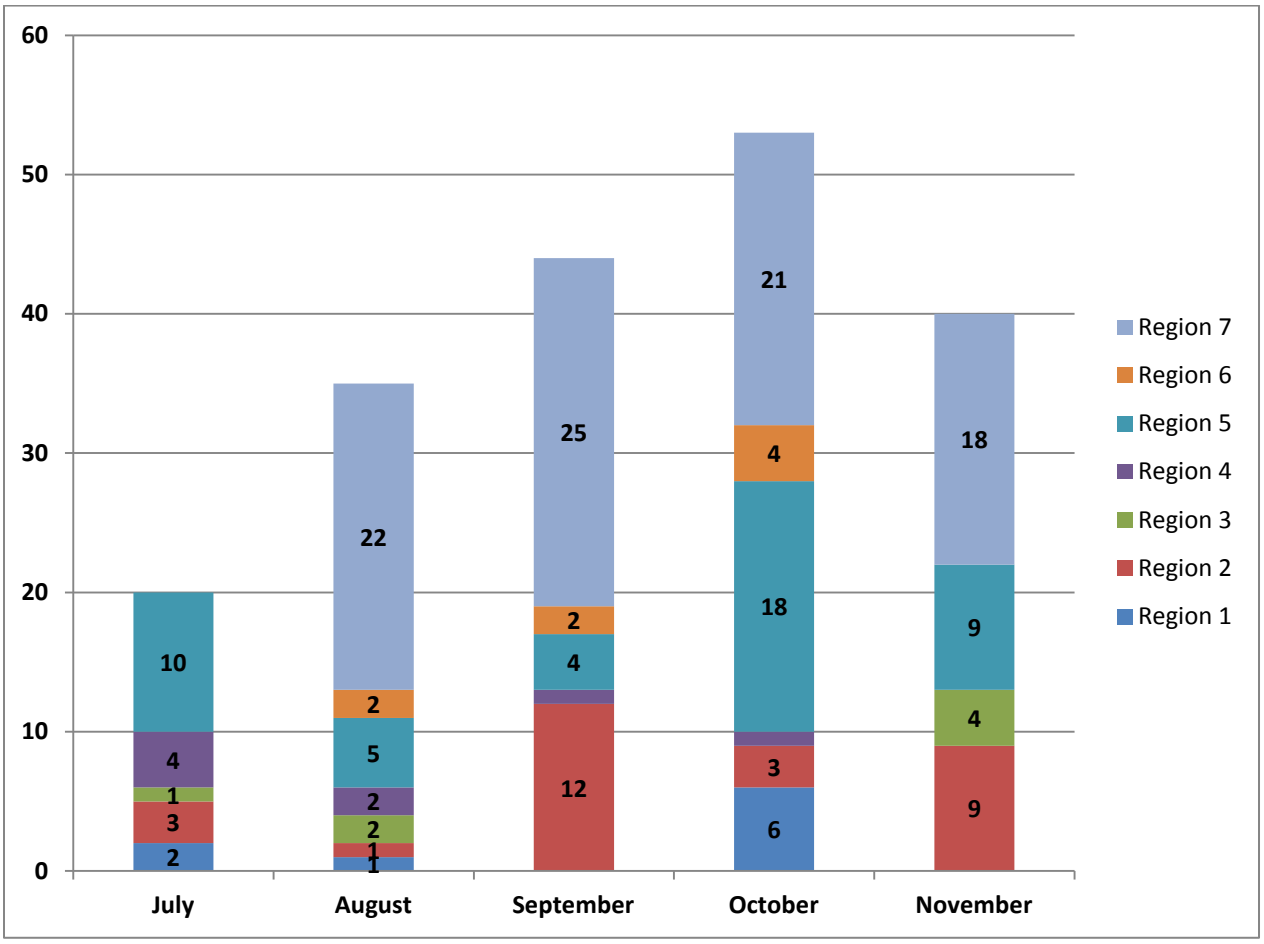


Table 7. TDO executed after ECO expired (corresponds with graph 7a)

Region	July	August	September	October	November	Total
Region 1	2	1	0	6	**0**	**9**
Region 2	3	1	12	3	**9**	**28**
Region 3	1	2	0	0	**4**	**7**
Region 4	4	2	1	1	**0**	**8**
Region 5	10	5	4	18	**9**	**46**
Region 6	0	2	2	4	**0**	**8**
Region 7	0	22	25	21	**18**	**86**
Total	**20**	**35**	**44**	**53**	**40**	**192**

Graph 8a. Transfers during temporary detention by region

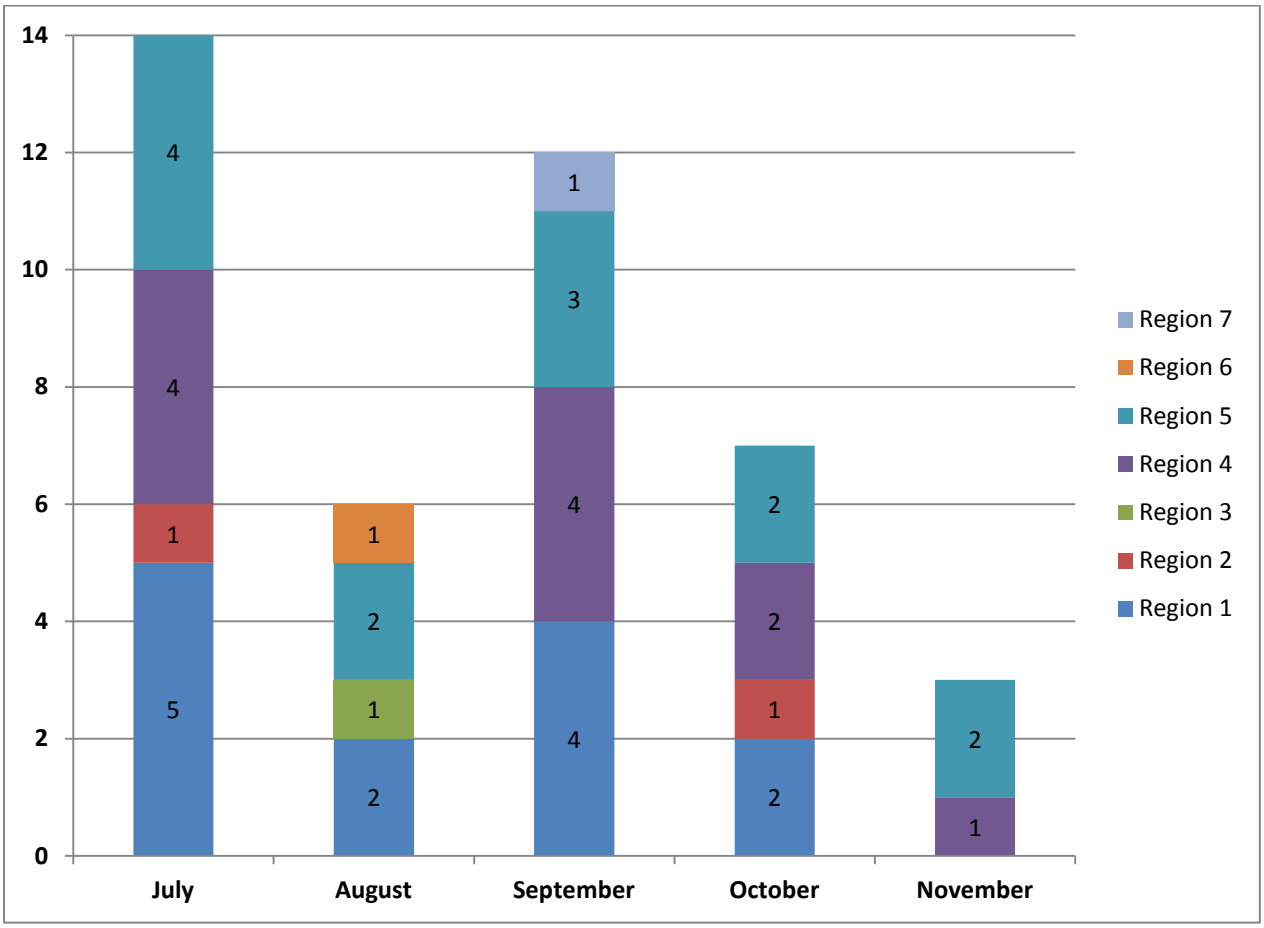


Table 8. Transfers during temporary detention (corresponds with graph 8a, pg 10)

Region	July	August	September	October	November	Total
Region 1	5	2	4	2	**0**	**13**
Region 2	1	0	0	1	**0**	**2**
Region 3	0	1	0	0	**0**	**1**
Region 4	4	0	4	2	**1**	**11**
Region 5	4	2	3	2	**2**	**13**
Region 6	0	1	0	0	**0**	**1**
Region 7	0	0	1	0	**0**	**1**
Total	**14**	**6**	**12**	**7**	**3**	**42**

Graph 9a. TDOs to state hospital without ECO by region

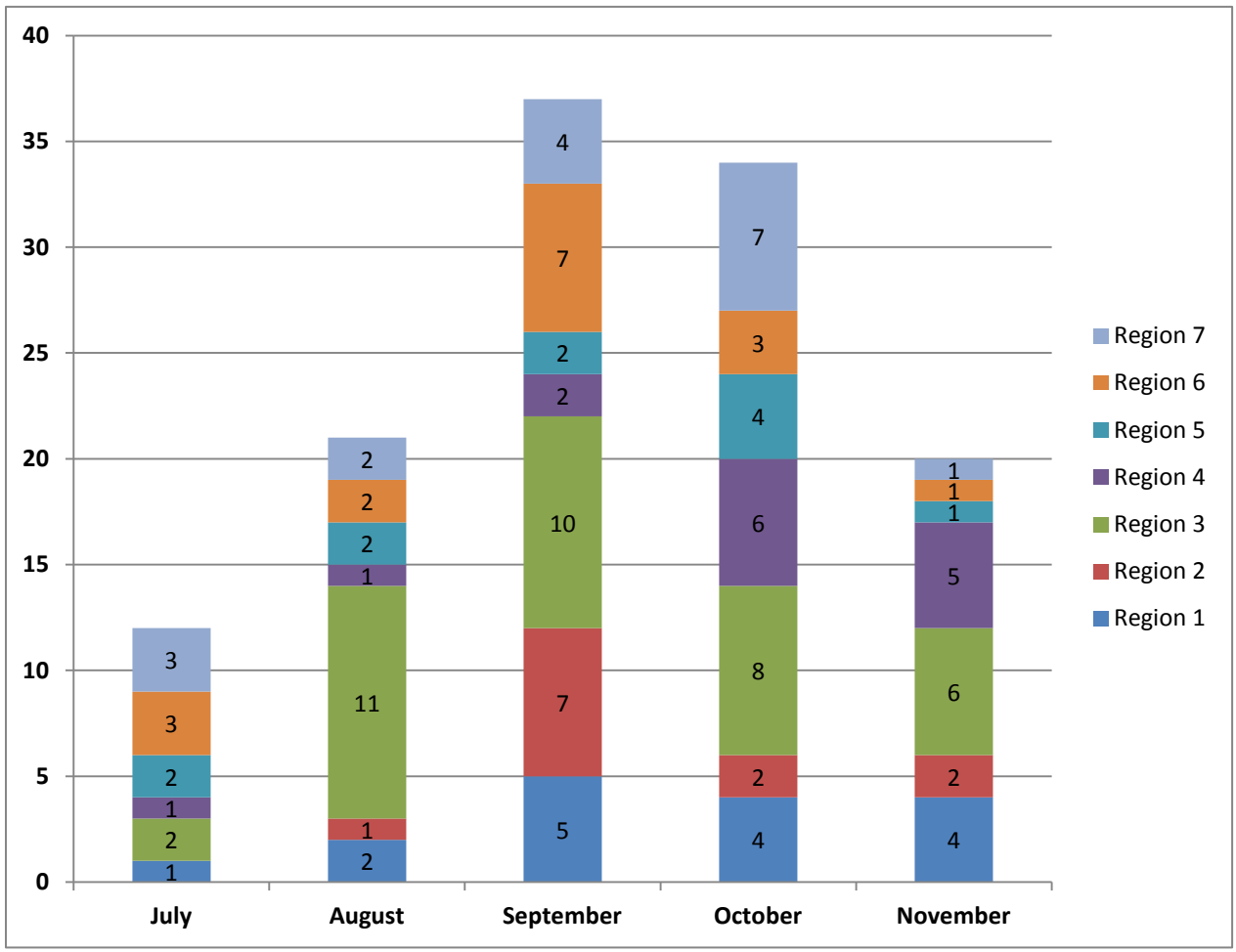


Table 9. State hospital TDOs without ECOs (corresponds with graph 9a)

Region	July	August	September	October	November	Total
Region 1	1	2	5	4	**4**	**16**
Region 2	0	1	7	2	**2**	**12**
Region 3	2	11	10	8	**6**	**37**
Region 4	1	1	2	6	**5**	**15**
Region 5	2	2	2	4	**1**	**11**
Region 6	3	2	7	3	**1**	**16**
Region 7	3	2	4	7	**1**	**17**
Total	**12**	**21**	**37**	**34**	**20**	**124**

APPENDIX D

DBHDS requires CSBs to report within 24-hours any event involving an individual who has been determined to require temporary detention for whom the TDO is not executed for any reason, whether or not an ECO was issued or in effect. These reports are sent to a DBHDS Quality Oversight Team that includes the DBHDS Medical Director, the Assistant Commissioner for Behavioral Health, the Director of Mental Health Services, and the MH Crisis Specialist. Each report contains the CSB's description of the incident and the CSB's proposed actions to resolve the event and prevent such occurrences in the future. In each case, the DBHDS Quality Oversight Team examines the report for completeness, comprehensiveness and sufficiency, and responds immediately to the CSB Executive Director if any further information is needed. In addition, DBHDS specifies any additional follow up actions that are deemed necessary, requests appropriate follow up communication from the CSB, and maintains an open incident file until the incident has resolved.

There were seven such events during the month of November 2014. The seven reported cases are summarized below. DBHDS has followed up with the relevant CSB in each of these events to gather additional information and to give to the CSB specific clinical and quality feedback about how each case was handled, what behaviors or procedures may have contributed to the event, what clinical and administrative or process issues need to be addressed in developing solutions to the problems encountered, strategies to implement with partner entities, etc. These case-driven DBHDS interventions are still ongoing at the time of this report.

Of the seven cases reported in November, four involved individuals were evaluated on a voluntary basis (i.e., the individuals were not under an ECO). Of these four individuals, three eloped from the site of the evaluation before the TDO was executed. Two of these individuals were subsequently located and temporarily detained, but the third individual was never found despite numerous efforts by local police, the reporting CSB and a neighboring CSB. A family member of this individual has subsequently spoken to the CSB, but the individual has not been engaged in CSB care.

Of the seven incidents reported in November, four were admitted for medical care in lieu of psychiatric care. Two of these individuals were reassessed by the CSB at a later time and transferred to temporary detention in a psychiatric hospital. One was reassessed and agreed to voluntary psychiatric hospitalization and the last remained in medical care. The case summaries follow.

1. The individual was brought to the emergency department by the police under an ECO after neighborhood residents complained that the individual was being disruptive. The individual was found in the bushes, disheveled and chanting to himself. The individual received medication prior to the arrival of the CSB evaluator due to his disruptiveness in the emergency department. The CSB evaluator determined that the individual met criteria for temporary detention, but the individual needed emergency medical care due to abnormal laboratory work. He was then admitted to medical facility for treatment. Following medical treatment the individual was reassessed by the CSB, a TDO was secured, and the individual

was admitted for psychiatric care. This individual was engaged in ongoing CSB services upon discharge. The DBHDS Quality Oversight Team's review reflected the positive outcome of this incident. The individual received necessary medical treatment and when medically stable was transferred for psychiatric care.

2. The individual was evaluated while in emergency custody (ECO) and was found to meet TDO criteria. Medical screening determined that the individual's medical needs were more pressing, resulting in admission to a medical unit. The individual subsequently agreed to voluntary admission to a local psychiatric facility upon completion of the medical treatment, and then was engaged in private outpatient services. The DBHDS Quality Oversight Team's review reflected the positive outcome of this incident. The individual received necessary medical treatment and when medically stable was transferred for psychiatric care.
3. The individual was seen on a medical unit after being treated for an overdose of medications. The hospital sought an ECO prior to the CSB evaluator's arrival. The CSB evaluator completed the assessment prior to the arrival of law enforcement with the ECO. The CSB evaluator determined that the individual met criteria for temporary detention. When the evaluator called the medical floor to advise the hospital staff of the location for TDO, the evaluator was informed that the individual had locked himself in a bathroom and had been found unresponsive after being left alone for several minutes. The individual was aroused by medical staff but was no longer cleared for transfer at that time. When the medical treatment concluded and the attending physician agreed to the individual's transfer, a TDO was obtained for a local psychiatric facility. The DBHDS Quality Oversight Team recommended that the CSB engage in discussion with the medical hospital regarding handling of this incident and plan a meeting with local law enforcement and magistrates to seek better communication and collaboration in handling these cases.
4. The individual presented voluntarily seeking assistance for mental health services, and reported a history of mental illness. The individual admitted not taking psychotropic medications as prescribed. The individual was assessed and reported thoughts of suicide with no specific plan, a history of prior attempts, and auditory and visual hallucinations. The individual was offered immediate voluntary admission to the local residential crisis stabilization unit (CSU) but he declined. The individual then became angry and requested to speak with another clinician. A second assessment was completed with the same information presented to the second clinician. The individual requested to phone a family member who could not be reached. The individual then went to the lobby and left the building. The CSB secured an ECO for the individual and engaged local law enforcement in searching for the individual. Police were dispatched to the address given which was not the correct address. The CSB continued attempts to reach the family member, and when contact was made the family member reported the individual did not want to go to the hospital. The CSB has made multiple attempts to locate and engage individual, but the individual has not been engaged in services at this time. Following consultation from the DBHDS Quality Oversight Team, the CSB changed its procedure to require consistent visual monitoring of all individuals who present

voluntarily and initiated a team review to occur within eight hours of any elopement during evaluation process.

5. The individual presented to the local emergency department (ED) seeking medical care and food. The CSB was contacted by the emergency department to assess the individual, who was hearing voices and wanting to kill himself to escape the voices. The individual refused voluntary admission, became agitated, grabbed his belongings and left the ED. The CSB evaluator attempted unsuccessfully to encourage the individual to stay, but watched to ascertain the direction in which the individual was going in order to provide information to the police. ED staff phoned the police at the evaluator's request. An ECO was obtained immediately and while law enforcement was searching for the individual, the CSB evaluator sought a bed for temporary detention. A TDO was obtained for the local state facility, and the TDO was executed approximately 13 hours after the individual left the emergency department. CSB subsequently engaged the ED to identify strategies to prevent such events. The CSB has also held discussions with police regarding the same issues. The DBHDS Quality Oversight Team's review reflected the prompt and diligent interventions by the CSB evaluator which contributed to the timely issuance of an ECO and eventual positive outcome for the individual.
6. An individual under an ECO was assessed and determined to meet criteria for TDO while in a local hospital emergency department (ED). A bed was found and the TDO was issued by the magistrate for a local community psychiatric facility. Prior to the execution of the TDO, the attending physician in the ED told the law enforcement officer having custody of the individual to leave and proceeded to arrange admission for the individual in the local military medical hospital via medical transport. Despite the written documentation that the TDO was being obtained, the local military hospital was notified and informed the individual was being admitted to a medical floor for a serious medical condition. The attending ED physician at the military hospital reported that if the individual tries to leave, he would obtain a medical TDO. TDO paperwork was returned to the issuing magistrate's office. The DBHDS Quality Oversight Team noted that the individual received the needed medical care. The CSB also maintained contact throughout the transfer process to ensure the individual received appropriate levels of care. DBHDS Quality Oversight Team requested that the CSB explain and address the discrepancies between the CSB plan and the ED physician's decision. The CSB then worked with the Director of the ED to educate the attending physicians about the TDO process and the need for closer coordination and communication between the ED staff, physicians and CSB evaluators. The CSB also advised the involved law enforcement agency of the breach of protocol and the law enforcement agency gave remedial information to all officers during their daily muster.
7. This individual presented himself for a medical problem to a local hospital emergency department (ED) and disclosed suicidal ideation during medical assessment. The individual was assessed by the CSB and determined to meet TDO criteria, but left the ED when informed of need for hospitalization. The CSB evaluator notified the ED staff of the

elopement and telephoned law enforcement for assistance in searching for the individual. An officer was dispatched to the ED and a report filed. The local police notified the police in the jurisdiction of the individual's home address. The evaluator notified the CSB serving the individual's home address, and the individual was found at home and taken into to custody under TDO with 1.5 hours of leaving the ED. The DBHDS Quality Oversight Team's review reflected the prompt and diligent interventions by the CSB evaluator which contributed to the timely issuance of a TDO and positive outcome for the individual. The CSB met with the Director of the hospital's Behavioral Health team to review the specifics of the case and request that preventive measures be implemented, including having individuals under evaluation placed in a room close to the nursing station.

Six of these incidents were reported to DBHDS in accordance with the established protocol within 24 hours. One report was delayed due to a misunderstanding of reporting over a holiday. As described above, in response to these cases, DBHDS and CSBs initiated targeted interventions with the individuals involved, as well as remedial efforts with service delivery partners to mitigate risks and improve processes and care coordination. DBHDS is monitoring these cases and actively working with regions and CSBs to identify and address factors contributing to the problems described in this TDO exceptions report. DBHDS is also clarifying data definitions and updating reporting protocols to ensure uniformity in data collection and reduce inconsistent reporting.